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ABSTRACT

This resource kit provides information intended to assist Australian disability liaison officers (DLO) and others who work with college students with psychiatric disabilities to understand the effects of mental health issues on learning in the context of post-secondary education. The guide suggests a range of compensatory strategies that aim to optimize learning outcomes for students and considers how institutions are best able to meet the needs of this group of students. The suggestions and strategies are the result of an Australia-wide research project that investigated the learning support needs of students with psychiatric disabilities. The kit is divided into the following sections: (1) understanding students with mental health issues (forms of mental disorders, and time frames and onset of mental disorders); (2) support processes and structures (principles of relating to students with mental health issues, suggestions for monitoring student progress, and advocacy options); (3) management strategies (collaborative linkages with external providers, dealing with unusual behavior, and student discipline); and (4) implications for policy and systemic changes, including internal and external systems. An appendix includes tables that provide suggested accommodation strategies for the following functions: perceptual, consciousness and attention, organizational and planning, cognitive, emotional, psychological, interpersonal, behavioral, and physiological. (CR)

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Mental health issues on campus

A resource kit for staff

A University of Melbourne –TAFE Collaboration project funded by NCVER

Jana Andrews
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General Manager, Equity and Learning Programs, University of Melbourne

The views and opinions expressed in this document are those of the project team and do not necessarily reflect the views of the Australian National Training Authority

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Contents

Section 1 Understanding students with mental health issues 1

What is a mental disorder? 1
Forms of mental disorders 2
Recognising and responding to signs of mental health impairment 3
Bio-psychosocial model of mental disorders 6
The prevalence of mental disorders 7
Time frames and onset of mental disordeers 9
How can staff help students with mental health impairments? 10
The role of study in the recovery process 12
Myths and stigma: Negative expectations 13

Section 2 Support processes and structures 17

Impairments and accommodations 17
Support personnel in the education setting 17
Principles of relating to students with mental health issues 22
Supported education programs as an option 23
Course and system flexibility and non-discrimination 24
Suggestions for monitoring student progress 27
Advocacy options 29
Resourcing implications of mental health impairments 30

Section 3 Management strategies 33

Referral 33
Collaborative linkages with external providers 34
Dealing with unusual behaviour 35
Student discipline 37
Implications for support staff 39

Section 4 Implications for policy and systemic changes 41

Internal systems 41
External systems 42
In conclusion 43

Appendices 45

The aim of this guide is to provide information which will assist disability liaison officers (DLOs) and others who work with students with psychiatric disabilities to understand the effects of mental health issues on learning in the context of post-secondary education. The guide suggests a range of compensatory strategies which aim to optimise learning outcomes for students and considers how institutions are best able to meet the needs of this group of students. The suggestions and strategies in the guide are the result of an Australia-wide research project which investigated the learning support needs of students with psychiatric disabilities. The research included extensive discussions with students and staff. The findings of this research are detailed in the research report which accompanies this booklet. A booklet has also been prepared for students.

mentalhealth resource kit

Section 1

Understanding students with mental health issues

Understanding students with mental health issues

A NUMBER OF STUDENTS in VET and post-secondary institutions have mental health impairments. Some may already have been diagnosed as having a mental disorder of some kind; others have the signs and symptoms but have not been diagnosed. Some students have had experience of mental illness in the past (which may or may not have an impact on their current functioning) while others may be at risk of developing it in the future. Because in most cases, the presence of mental disorders is not obvious, it seems 'hidden' and requires sensitivity to its possible existence.

Mental disorders are one type of illness or disorder included in the definition of a disability or an impairment, so need to be included and considered in educational practices in ways which avoid discrimination.

Mental disorders affect the thought processes, emotions, perceptions of reality and judgement of students and may also result in disturbed behaviour. Mental illness can have a strong impact on a student's level of functioning, both academically and socially. Further, students may be affected by the demands and stresses of study and interacting on campus, which may worsen existing mental health problems.

Mental disorders potentially interfere with a student's ability to study and adapt to the campus environment, through impairments in concentration, motivation, study, organisation, energy levels, self-esteem, social adjustment, emotional functioning, contact with reality, or behaviour. Through appropriate support, educational institutions can make a critical difference to the success of students with mental health issues. Knowing why and how to accommodate the needs of these students is essential to that goal. While each person is individual and therefore will have a unique set of qualities even within the mental health framework, understanding some general patterns of mental health impairments can be helpful in meeting the needs of students.

What is a mental disorder?

A mental disorder is defined as a 'psychological or behavioural syndrome (pattern) associated with distress or disability (in an area of functioning)' (DSMIV, xxi). The syndrome must be *clinically significant*—that is, diagnosed by a clinician to meet certain criteria for the nature and extent of the signs and symptoms. The main clinicians are psychiatrists and psychologists (usually clinical). Mental disorder may be considered a

medical illness or disorder, and it is increasingly evident that there are neurological or physiological changes and/or environmental, stress and physical factors (such as allergy and nutrition) associated with many of the mental disorders. The syndrome is not simply an expected response to a particular event, and is not limited to relations between the person and society.

'Mental health issues' are issues that relate to mental health or lack of it. Mental illness can involve a number of aspects—the episodic nature of some mental disorders, various stages of recovery, the sometimes changing diagnoses and the existence of possibly concurrent or interacting mental disorders (e.g. post-traumatic stress disorder followed by major depression). Because of this it may be more respectful and flexible to refer to mental health issues or to the impairment the person has, rather than using the term mental or psychiatric disorder.

The stigma of mental illness or mental disorder still exists in our (Western) culture, and few of us would like to be referred to as mentally ill or disordered, if depressed, anxious or going through an emotional breakdown. A mental health issue, on the other hand, is something that can be approached as if by fresh vision, and accepted and reflected upon carefully and sensitively. A mental health impairment more specifically focusses attention on the decrease in functioning or ability that is implied in having a mental disorder. Impairment is not as conceptually absolute as the word 'disability' implies.

Forms of mental disorders

Mental disorders can take a number of forms, with a central feature of the person, the self, functioning differently in terms of psychological, emotional or behavioural patterns. Distress and/or impairment are the main aspects. Signs and symptoms may vary considerably across individuals, time or situations. Patterns of signs and symptoms are grouped according to theoretical/clinical orientations to form a cluster called a specific mental disorder such as anxiety disorder. Two major systems of classification are used by the medical profession: DSM IV from the United States and the ICD 10 from the World Health Organisation. Other less-recognised ways of identifying disorders are emerging in this complex field.

According to the DSM IV, mental disorders can take a number of forms. For example those related to development (autism, attention deficit hyperactivity disorder), mood (depression, bi-polar disorder), anxiety (phobias, panic), schizophrenia, drug and alcohol dependence, eating (anorexia nervosa), impulse control (gambling, conduct disorder), sleep, dissociation (multiple personalities), adjustment following a stressful event, body (pain disorder), cognition and memory loss, sexuality, other medical conditions, and personality disorders (borderline). Personality disorders may be additional to any of the previous disorders.

Mental disorders such as these involve significant distress or impairment in functioning and are therefore likely to decrease the ability to study or interact with others on campus. Some medications also have adverse effects. The episodic nature of some disorders, and student insight into their condition (and their ability and willingness to disclose) are additional factors which further complicate the opportunity for students to communicate and respond appropriately in the educational setting. Despite these difficulties, the student may have a strong desire to study and obtain a qualification to improve their life opportunities.

Recognising and responding to signs of mental health impairment

Recognising signs of mental health impairment and responding to them are two different functions with different purposes. Both recognition and response require utmost care, as the consequences of inaccurate assumptions or interventions are potentially counter productive.

Staff are not expected to diagnose mental disorders—*diagnosis is a complex and time-consuming process*, best left to the professionals. Disability support staff counsellors, teachers and others who work with students with psychiatric disability are not expected to be diagnosticians, but an awareness of the signs of mental illness is useful because of the following:

1. The student may be experiencing a mental disorder for the first time and may benefit from professional treatment, which without their personal and educational functioning may deteriorate further.
2. Students may be approaching a relapse of a previous condition, and prevention or early professional intervention may help.
3. Awareness of the possibility of mental health issues may act as a cue to, for example: greater consideration of the student's situation and progress, more attuned communication style or preventing and minimising stresses in the educational environment and provision of appropriate adjustments.
4. Other conditions (e.g. physical disability, non-English-speaking background, domestic violence) may appear more noticeable, and may 'mask' the co-occurrence of mental disorder, which may eventually impact on their well-being and educational functioning.
5. Even if respecting the student's choice not to disclose possible mental illness, where signs indicate something seems out of the usual, it is important not to jump to conclusions that the student is 'stupid', 'lazy', 'crazy', 'difficult' or 'unco-operative'.
6. The student's reaction to others' responses to him or her needs to be monitored and any dysfunctional dynamics need to be addressed. It is not unusual for young students with mental health issues to be teased or bullied, and they can overreact with defensiveness and aggression. Some vulnerable students with mental health issues may be sexually harrassed and become further traumatised, anxious or depressed.

Signs indicating mental health impairment

General signs indicate 'something is not quite right', but there are many other factors besides mental health issues which affect students. These include: physical illness, 'normal' stresses or life problems, existential choices, educational adjustment and stress, family responsibilities or more pressing needs. Nevertheless, these signs could point to the possibility of mental health issues (but it is important not to make this assumption lightly).

General signs:

- lower attendance or changed pattern of attendance
- late arrival
- missing morning lectures, attending afternoon ones
- unusual communication style or difficulties
- student's studies deteriorate
- student becomes more withdrawn or isolated
- student's behaviour changes (e.g. neglects appearance)
- student's emotions change or are labile (volatile)
- talks or writes about things which don't make sense or are very unusual

More specific signs:

- student has difficulty concentrating, following a conversation or remembering things
- student appears tense, anxious, depressed, suspicious, irritable, angry or flat
- student is suicidal
- student's energy level is very low or very high
- student seems to create repeated conflict between staff
- student extremely pre-occupied with a particular theme
- student extremely thin, eats poorly
- student is psychologically dependent on others
- student has fears, panic attacks, avoids certain situations or things
- student seems distressed
- student's motor behaviour is different: e.g. restlessness, 'freezes' or unusual movements
- Student's speech is disturbed: e.g. very loud, soft or pressured; flight of ideas
- student's level of consciousness is unusual: e.g. drowsy, disoriented, doesn't react to environment
- student does odd or bizarre things
- student is unable to distinguish reality from fantasy
- student has poor insight into his/her personality or poor judgement of situations

- student thinks illogically, tangentially, over inclusively, repetitively, or in a too concrete or too abstract manner
- student's content of thought seems disturbed: e.g. delusions (false beliefs that cannot be corrected by reasoning) or highly pre-occupied or obsessive
- thoughts slowed, sped up or blocked
- student believes their thoughts are controlled by outside forces or transmitted by magic means
- perceptual disturbances such as hallucinations and illusions

How should staff respond?

Responding to signs will require careful thought, because of the need for confidentiality, respect for the student's autonomy, and possible involvement of other staff or services. There are some basic issues to be considered:

- Definite signs of mental health issues require a clinical assessment by a professional. A diagnosis of a mental disorder indicates a possible need for treatment.
- The student may or may not agree to be assessed or treated.
- The student may have a different explanation of their condition.
- The student may already have a diagnosis and be receiving treatment.
- The student may have experienced and rejected treatment, or have been discharged, or may not have been fully treated.
- The treating professional or case worker should be consulted if another referral is considered.
- The student's vulnerability could be exacerbated by asking about their symptoms or eliciting a history or explanation of their state.
- The student may want to guard his/her privacy.
- The student may fear stigma and discrimination or inappropriate interventions.
- The student may not know that he/she may be unwell and become very depressed after a diagnosis.
- Student may not be able to describe the experience or situation.

The focus should be on behaviour or study performance which seems to be getting in the way of students' academic outcomes or interfering with group processes. It is important to be clear about what the issue of concern is (e.g. behaviour, study skills or meeting course requirements).

Students, including those with mental health issues, may be sensitive to non-verbal signs, especially of rejection, judgemental behaviour or ambivalence. It is important to be accepting and genuinely interested in the student's progress, as with any student. It is useful to include

preferred non-verbal elements such as: sufficient eye-contact (not necessarily constant), a calm and concerned voice, a friendly or neutral facial expression and smiling (when appropriate). Creating non-verbal rapport is critical to a good working relationship.

Bio-psychosocial model of mental disorders

The study of mental disorders is still evolving and there are few absolute answers. There is an emerging consensus, however, that mental health is an interaction between the biological, psychological, social and even spiritual factors.

Biologically, a number of studies show the neurological bases of mental disorders. Also nutrition, chemical environmental pollutants, other diseases, prenatal factors, sleeping patterns, substance intake, brain injury or tumors, neurotransmitter abnormalities and genetic predisposition have all been linked to development of mental disorders.

Psychological factors are strongly implicated in mental health in terms of cognition, emotions, and their interaction, behaviour patterns, and self-structure (the ways the person organises his or her subjective experiences into coherent meaningful patterns). A healthy person is able to achieve an optimum balance between the maintenance of his or her self-structure, and openness to new forms of experience. However, it is through rigid pathological self-structures, or underdeveloped self-structures with unfulfilled needs, that clinical mental disorders and personality disorders may arise. Social factors include the influences of others, such as early care-givers, teachers, family relations, peers, work colleagues and others interacting with the person.

The inter-subjective perspective describes the interaction between the subjective (meaningful) worlds of both parties, because it is primarily the subjective impact on one another that influences outcomes. For example, when one person smiles, the other person may interpret the smile as contemptuous and withdraw or react. An emerging element in the model is spirituality. Being more sensitive to altered states of consciousness, alternative perspectives, sources of creativity, the fragility of well-being and life, a heightened sense of sharing between people with similar experiences, or recovery can bring about a deeper sense of meaning and spirituality. There are complex and perhaps obscure interactions between the bio-psychosocial elements. However, in each person, a unique set of factors will come into play, many of which will rarely come to light. Treatment, rehabilitation, lifestyle, recovery and educational support will vary according to the individual's needs.

The prevalence of mental disorders

It is estimated that 20 per cent of all Australians will experience a mental disorder in any one year (SANE 1998). The estimated prevalence of 'severe' mental disorders over a year is three per cent (includes schizophrenia, bipolar disorder, severe depression, panic disorder and obsessive-compulsive disorder). Based on the 1998 ABS publication *Mental health and wellbeing in Australia*, the prevalence for some specific disorders in Australia is as follows:

One-year prevalence of mental disorders by age

18 – 24:	26.6%
25 – 34:	21%
35 – 44:	19.9%
45 – 54:	17.5%
55 – 64:	12.3%
65+	6.1%
Total	17.7%

Excludes low prevalence disorders such as schizophrenia at 1%

The prevalence in the younger age groups (the most frequent age groups at TAFE or university) is extremely high. The differences in gender show males are more likely to have a substance abuse disorder while females are more likely to have anxiety and affective disorders.

One-year prevalence of mental disorders in 18–24 year olds by gender

	Total	Male	Female
Anxiety	11.2%	8.6%	13.8%
Affective	6.7%	2.9%	10.7%
Substance abuse	16.1%	21.5%	10.6%
Total	26.6%	27.3%	25.9%

The most frequent disorders are depression, alcohol dependence and harmful use, post-traumatic stress disorder and generalised anxiety disorder.

Prevalence in post-secondary education

Kessler et al. (1995) investigated the impact of psychiatric disorders in the US and estimated that 14.2 per cent of high school dropouts and 4.7 per cent of college dropouts were persons with psychiatric disorders.

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Prevalence of specific mental disorders in 1997 (all age groups)

ANXIETY	
Post-traumatic stress disorder	3.3%
Generalised anxiety disorder	3.1%
Social phobia	2.7%
Panic disorder	1.3%
Agoraphobia	1.1%
Obsessive-compulsive disorder	0.4%
Total	**9.7%**
AFFECTIVE	
Depression	5.1%
Dysthymia (depressive personality)	1.1%
Total (includes bi-polar and mania)	**5.8%**
SUBSTANCE USE	
Alcohol harmful use	3.0%
Alcohol dependence	3.5%
Drug use disorders	2.2%
Total	**7.7%**

Extrapolating prevalence from the general population in Australia to post-secondary students is not straightforward. It has been argued that people with mental disorders are less inclined to study because of their impairments or hospitalisation. Rehabilitation has focussed mainly on employment and, recently, psychosocial outcomes rather than education and training, although there are State differences in these emphases.

However, with the de-institutionalisation of the mentally ill and more effective medical and psychological treatments, there are many people in the community in a state of partial or complete recovery who are eager to undertake some form of post-secondary education.

A number of counsellors and disability liaison officers have noticed an increase in the number of students who are willing to disclose or who manifest signs of mental disorders. In some educational institutions, the proportion of students with disclosed disabilities who have psychiatric/mental disorders (as a percentage of the students accessing disability support) has grown from the lowest to the highest compared to other disabilities.

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Time frames and onset of mental disorders

The longevity of mental disorders varies greatly. Some, by definition, are of shorter duration (such as an acute stress disorder) while others can be long term (such as autism or personality disorders). With some disorders, such as schizophrenia, people vary in that a third recover within months, a third recover somewhat, and a third have significant continuing symptoms. Some people with mental disorders seem to recover spontaneously, many through treatment and support, and some do not recover for a long time, even with treatment.

The onset of many mental disorders occurs in adolescence or early adulthood, and the chances are that many students in post-secondary education may be experiencing signs and symptoms of mental health impairments for the first time.

Identification of a mental disorder, acceptance of the need for treatment, and help-seeking may take a long tim. Efforts are directed by some progressive mental health services (e.g. EPPIC in Victoria) to provide early intervention and even prevention (through identifying pro-dromal or indicative signs and symptoms).

The student with recent onset

Any student with a recent onset of a mental disorder, even if treated, may be in a state of confusion or ambivalence about their condition and may not be aware how it might affect their study or functioning on campus. The student may not realise that there are services that can help, or that they have a right to accommodations. They may not know how to 'negotiate the system', how to apply for special consideration, to obtain disability services, to vary their enrolment or the Youth Allowance, or even that they might benefit from advocacy or someone to co-ordinate their needs on campus.

Retrospective accommodations, which allow for a lack of self-awareness, awareness of administrative procedures or student services may need to be provided. Conversely, if the student's mental disorder is imputed or provisionally diagnosed, they may be eligible for prospective accommodations to prevent deterioration of their condition. Liaison with the student's treatment providers (with the student's permission) may be very useful (or essential).

Students receiving treatment

Students who have received treatment for their mental health issues and are now in the process of recovery tend to be more aware of their needs; more articulate, assertive and better able to demand assistance and accommodations. However, managing their changing situation and studies

and campus experience can be very stressful. The possibility of relapse is present, and both prevention and early response are recommended.

The student recently discharged from mental health services

The student who has been discharged from mental health services may be in a more precarious position if they are still not totally well. While they may have access to a private medical practitioner, they may not consult them sufficiently or may reject medications. Unless they seek out a bulk-billing psychiatrist, they may have difficulty paying for a private psychologist or psychotherapist and thus not benefit from therapy. Some of these students may not be aware of, or choose to access, study support, if only that they no longer wish to be identified with 'psychiatric' labels.

Their needs in the educational context may be quite high and their study skills in need of improvement. They may find study and the interpersonal environment on campus extremely stressful and may benefit from intensive services and the full range of accommodations.

Those students who are well on the way to recovery may find that the impact of their mental health impairment on study and functioning on campus is minimal or less marked. Nevertheless they may still be entitled to some accommodations or services and may find some situations stressful. Prospective accommodations (those preventing relapse if it can be predicted on past experiences) may still be required.

Many students with mental health impairments have a realistic assessment of their situation, yet still find studies demanding. Often however, these students are not aware of their rights and campus services, and may not easily identify with having a disability or with the implications of disclosing their illness to their college or university. Some students may not choose to disclose on grounds of privacy or fear of stigma, but other options such as special consideration may be appropriate.

Students with ongoing mental health issues who have studied for some time tend to have a very good assessment of their needs and generally seek assistance if required. However, due to the episodic nature of mental health issues, and the fluctuating (and developmental) nature of the illness, these students may require ongoing monitoring and adjustments of services.

How can staff help students with mental health impairments?

Students with mental health impairments may be vulnerable to stress on campus, because of their weakened self-functioning. Students may find it hard to meet their normal, let alone extended, needs for emotional support from others, because their disrupted functioning may interfere with their ability to communicate a coherent account of themselves to others (Palombo 1996).

The result may be a deterioration in the student's self-cohesion (ability to maintain a sense of self). This may sometimes be observed in a student's speech or writing, or as evidenced by disorganised behaviour, helplessness or passivity, disturbed emotions, lack of boundaries, a sense of fragmentation, or lack of academic progress. To succeed as a student, students with mental health impairments need to be affirmed in their self-esteem, to be protected and guided when required and to have a sense of belonging with others.

Students need ambition to fully develop their potential and to make a commitment to achieve goals such as the completion of a course. Staff can provide recognition, affirmation of the student's sense of self and celebration of the student's efforts and achievements that contribute to academic progress and self-management. By improving the student's sense of efficacy, self-esteem and academic ambition will grow.

Prospective students with mental health impairments may need additional assistance to develop their self-esteem and academic ambitions. Early vocational counselling may play a significant role in building self-esteem and encouraging the student role.

Provision of safe and structured learning and social environments is particularly important to students with mental health impairments, who may feel vulnerable to stresses that undermine their sense of security. Useful support could include the provision of training in study skills, time management, self-organisation, stress management, resilience, self-management of emotions, advocacy, coping strategies and communication. Many students will also need assistance with the negotiation of accommodations. Availability of a quiet area (a sick bay or lounge area) where students can retreat from 'the madding crowd' was nominated by many students as being partcularly useful. Peer support programs also assist students to build or strengthen their goals, values and interests. Other ways of obtaining the feeling of belonging may be through telephone or internet contacts with students with similar interests or mental health impairments.

Because the needs of many students with mental health impairments are complex and can change over time, an ongoing key support worker or case manager may facilitate planning and co-ordinating the assistance required for academic success. Whether this role is taken by a counsellor, disability support staff or some other staff member will depend on individual circumstances. However, in all cases it should be acknowledged in the staff member's position description and the implications for staff time (and therefore resourcing) should be acknowledged in disability funding.

From the perspective of the student with mental health issues, the educational environment may seem overcrowded, competitive, demanding, powerful, fear-inducing, rigid, unfriendly or even harmful. The student may take on issues personally, even when not directed at them.

They may not wish to be sociable or assertive in order to avoid stress. They may feel hurt or angry if misunderstood. They may become involved in conflicts if provoked (from their point of view). A number of students reported that maintaining relationships is the hardest part of being a student.

From the perspective of students without mental health issues, understanding students with mental health impairments may be a challenge. Some students may become fearful, may label, or even take advantage of the vulnerable student. Sometimes students become envious of the perceived 'privileges' that the student with mental health impairment receives. Often students are not aware of the mental health impairment and may react negatively to the characteristics of the student. Other students may be empathic and tolerant towards students with mental health impairments, but may become distressed, concerned or frustrated by not knowing how to respond.

Both teaching and support staff may have many subjective viewpoints on students with mental health impairment. Some are apprehensive of the unknown or of potential violence and are uncertain of how to respond. Some are very understanding, especially if they have a relative with mental health issues. Sessional staff may find it harder to cope with students with mental health issues because often they do not have the time to follow up.

Many staff are concerned about the lack of allotted time to deal with disability issues adequately. Some label the student as lazy, strange, attention seeking or having other negative attributes, and do not take the student's, the doctor's or the counsellor's statements seriously. Some staff believe the student is taking advantage of the system to gain privileges, and may resent providing certain accommodations. Staff often try to help, but may become over-involved or burdened. Sometimes staff are overly influenced by other staff's viewpoints and may act inappropriately.

It is important for all staff to be aware of the subjectivity of their viewpoints, and to observe how their viewpoint is interacting with the viewpoint of students with mental health impairments, other students and other staff. By discussing this with trained professionals, they may be able to adjust their viewpoint or their interactions so as to prevent or repair any misunderstandings, conflicts, discrimination, student's withdrawal or impaired functioning. If problems begin to occur, mediation may be useful and prevent escalation of grievances or potential conflict.

The role of study in the recovery process

Recovery is a key concept both for people with mental health issues and staff. Recovery signals a return to, or redevelopment of, a better quality of life where mental health and self-esteem are sustained most of the time and satisfaction in other areas of life can be achieved. Studying can contribute to

recovery by providing a regular structure and a valued student role, by stimulating and enhancing the student's interests, knowledge and skills, and by increasing the chances of securing a fulfilling job. By interacting with others on campus, the student can develop a new identity and meet their psychological needs from supportive others.

Studying can empower students with mental health issues, by providing an opportunity to express their point of view and contribute to society, to negotiate or initiate improvements, or to share with and encourage others. The focus is on future successes rather than past problems, bringing hope and renewed energy. A complete cure is not necessary for educational or work success; many people are able to cope in these environments. In some cases, their mental health issues may enhance their creativity or understanding of others. Many mental disorders are temporary and some of the longer-term ones may be manageable. As one student commented:

> *The only cure is coming to a better understanding of self, to be better able to tolerate one's experiences.*

Many students are learning to manage their symptoms by viewing them as only one part of their being. Staff need to see the potential for recovery for students with mental health issues, and to participate in conveying hope by encouragement and willingness to make study success possible, even if that requires additional effort on their part.

As another TAFE student said:

> *Doing school is the best therapy (to reverse the damage I have suffered in childhood and return to real life). Before you start, get some counselling, build stamina and strengthen the self. Do some literacy and some voluntary work, then come to TAFE. Analyse what helps and what doesn't, and what the triggers are. Express your feelings and do something soothing when distressed. Get staff to help, by encouraging you, opening your eyes to the possibilities, and building on your strengths. Get supportive people around you, and find a safe and comfortable environment. My imagination and confidence was taken away, and I was lost in the world, but now I am on the way to recovery.*

This student has required extensive support and accommodations for several years, and sometimes it still isn't easy to study, yet her determination and effort have achieved tremendous progress.

Myths and stigma: Negative expectations

Many people carry attitudes towards mental disorders that are less than positive. This may have developed from parents' attitudes, from sensationalist media depictions, from personal encounters with very disabled people (e.g. street dwellers), or other reasons. These attitudes are often deeply entrenched and are not always fully articulated, although they may be felt as uneasy feelings. Emotions may include fear, sadness, contempt, disgust or even anger. Negative attitudes can have varied

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content about people with mental health issues, mostly based on faulty or insufficient information, and when shared by others can be thought of as 'myths'. Negative attitudes will lead to negative expectations, and may have a damaging effect on students with mental impairments.

Some myths associated with mental illness

Mental illness is not 'real'

This is probably based on the assumption that only physical illness is demonstrable—it ignores the genetic and neurobiological evidence involved in some mental disorders. Students with mental health issues may be branded as lazy, attention seeking or taking advantage of the accommodations that are available. The complexity of human suffering, the extremes of life experience, and the fragility of self-esteem are ignored.

People with mental health issues are different to us, they are 'other'

This is based on intolerance of differences and lack of awareness of our own propensity to reduction of mental health, such as in times of extreme stress, poor nutrition, or major losses. Many of us have periods of anxiety, depression or distractions (e.g. addictions) at some point in our lives, but we wouldn't like to be called 'strange', 'crazy' or 'weird', or be ostracised or devalued as 'other'.

People with mental health issues are less able or intelligent

A mental disorder does not necessarily mean a reduction in intellectual ability or other abilities. Some people may have a greater capacity in some areas (such as artistic talent), others obtain higher qualifications. Nevertheless, people with mental health issues may experience some impairments in cognitive or other functions which may slow them down, interfere with perseverance, or affect some aspects of their performance. It does not mean they are 'stupid' or 'hopeless'. Most recover or learn to compensate with other skills or tools.

A staff member who judges that a student may find a specific course too challenging, may:

- be wrong, or underestimate the student's ability or assistance possible
- discourage a student who may have been able to complete successfully
- be right, but take away a student's 'right to fail'

- direct the student into alternative courses which may be less satisfying and therefore increase the chances of withdrawal
- lower the student's overall expectations and self-efficacy

People with mental illness cannot do particular courses

This attitude is often based on the assumption that the student will not be able to meet the inherent requirements of the job in the future. This judgement, however, is reserved for employers only, and a non-employer cannot make that judgement on behalf of an employer, especially without knowledge of the accommodations the employer may be able to provide for the employee. Further, the student's functioning may improve in the future Other career options may also be available, and the student has a right to study for other purposes, such as volunteer work, leisure interests, teaching or journalism.

Please note: the educational institution cannot reject students because they can't meet the 'inherent requirements of the course', as this is not permitted in the Disability Discrimination Act except for the clause of unjustifiable hardship to the institution.

People with mental disorders are likely to be violent.

Statistical evidence for violence in those with mental disorders is very weak, although people not receiving treatment who have a history of violence, and those who abuse drugs or alcohol, do have a higher risk (SANE Factsheet 1997, 'Mental illness and violence'). However, the risk of suicide is extremely high, at 10 per cent. The lifetime risk of someone with schizophrenia to seriously harm or kill another person is only 0.005 per cent. The media wildly exaggerates this risk, and greatly contributes to the fear of the general public. While some students with mental health issues may have difficulty regulating their emotions, actual violence is unlikely.

Everything about the student is related to their mental disorder

While some or even many aspects of a student's behaviour or personality may be affected by their mental disorder, many aspects may not be. Writer's block, transition maladjustment, exam anxiety, performance anxiety occur in all students, not just those with a mental disorder. The student with mental health issues deserves to be supported as an individual and given appropriate assistance on campus.

One student with mental health issues was viewed as a 'strange ghost, drifting in and out of classes, never saying a word', but the reason for this behaviour was that financial difficulties led him to

discontinue his enrolment. His reticence in participating related to his enrolment status, not his mental illness.

Students with mental health issues are behaviourally difficult

While some students may appear very focussed on their own needs and the failure of others to address these needs, the student's attitude can also be perceived as self-protective and quite rational. Such students may have difficulty in regulating their emotions or impulses, but some accommodations and strategies (e.g. taking the student outside to calm down) may cause minimal disruption. It also needs to be mentioned that some behaviour may be beyond conscious control (e.g. restlessness), or may be changed only with significant effort and skill (e.g. through review of medication, therapeutic intervention, self-control training, or environmental modifications).

The stigma of mental illness

Some students with mental health issues report that the primary difficulty they experience is not related to learning, but to how they feel in the academic and campus environment, and the stigma they often experience. Students with mental health issues do not wish to be disparaged, penalised, feared or avoided as a result of stigma. That is why confidentiality is so important. Once the knowledge of the mental health impairment is known by staff or other students, negative interactions may follow. Even subtle messages, non-verbal signals, or overheard conversations can betray the negative content of the communication, and hurt or anger a student with a mental health issue. Sometimes stigma can add to the stress the student is already experiencing, and act as a trigger to further depression, withdrawal or suicidality.

Students have made comments such as:

- The worst treatment I got was from my class mates.
- There's too much ignorance and prejudice.
- I was harassed.
- People treated me differently.
- I felt like a freak.

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Section 2

Support processes and structures

Support processes and structures

Impairments and accommodations

A NUMBER OF POSSIBLE impairments, accommodations and other assistance are presented in tables in appendix A. The impairments listed are not exhaustive and suggested accommodations are only suggestions and may need to be agreed upon by student and staff and be tested in individual situations.

Both the impairments and appropriate accommodations may take time to be identified and tested. Because of the variable nature of some impairments, and the psychosocial complexity of some of the accommodations, a continual monitoring of adjustments, and learning may need to take place. The implementation of some of the accommodations may require significant collaboration between a number of staff, as well as sensitive introduction and training.

Support personnel in the education setting

There are a number of staff in most institutions who are able to help students with psychiatric disabilities or mental impairments. The following list of strengths, weaknesses and oppportunities comes from discussions with students and feedback from the surveys which were sent out to students in TAFEs and universities across Australia. Effective cross-referrals between staff will optimise the support available to students while reducing the workload on staff.

Disability support staff

Disability staff (disability liason officers, special needs co-ordinators etc.) are generally the first staff contacted by students or by teachers who are concerned about a student in their class. The current strengths of the disability staff in working with students with mental health impairments are perceived to be:

- extensive knowledge of disability discrimination law and rights
- interviewing expertise and knowledge of educational context
- ability to provide functional assessment and planning of support measures
- skills in organisation and co-ordination of accommodations
- skills in negotiation and advocacy
- flexibility and timely responsiveness
- ability to facilitate liaison with academic staff

- brokering of tutoring, notetaking and other services
- pragmatic, problem-solving approach
- policy development

Possible weaknesses:

- places students in disability context, (psychiatric terminology is not popular with students)
- variable knowledge of mental disorders, impairments and appropriate accommodations (unless specialised in mental health)
- large client loads
- insufficient time for intensive case management
- difficult to service across multi-campus facilities
- student disclosure may lead to stigma (from staff and fellow students)
- significant administrative component to role

Opportunities for development:

- identifying training and support needs of staff
- anti-stigma campaigns
- skill development in mental health issues
- provided with opportunity to debrief after incidents
- training students in self-advocacy, in conjunction with student associations
- inclusion of mental health impairment in all disability literature

Campus-based medical services

The health service is provided in universities but not usually in TAFE/VET-only institutions. The health service may employ general practitioners, psychiatrists or nurses, on a full-time or sessional basis. The health service may prescribe or review medication, liaise with academic departments re student absence, refer to psychiatrists, or other mental health services, provide some counselling or hypnosis, consult to management and staff re student management. It is advantageous if at least one medical officer experienced in mental health is available on campus for timely access by students with mental health issues, even on a sessional basis.

Opportunities for improvement include providing a sessional psychiatry service on campus, and including a consultation liaison psychiatry service to staff and management.

Counsellors

Perceptions of the role of counsellor noted the following strengths and opportunities for development.

Current strengths:

- approachable to students with mental health issues
- client-centred focus

- generalist role (e.g. personal, educational, vocational and possibly financial counselling) in most TAFE/VET-only settings; perceived as flexible and responsive
- case management (co-ordination of services, referral and follow up)
- non-medical model of mental illness (students may reject the medical model)
- problem-solving and facilitative approach
- advanced empathy and relationship building skills

Possible weaknesses:

- incomplete knowledge of disability rights and possible accommodations/adjustments
- short-term counselling policies
- limitations in accessing the service (e.g. waiting lists)
- students may not wish to be associated with 'counselling' service

Opportunities for development:

- better assessment practices including differential and provisional diagnosis of mental disorders
- extending clinical expertise/skills, knowledge in mental health issues including dual disabilities
- developing accommodations and specialist services e.g. ongoing counselling for students with mental health issues.
- differentiation or development of counsellor roles in maintaining the student in education, e.g. primary treatment, secondary or adjunct treatment, supportive therapy, secondary consultation to staff, psychosocial and educational rehabilitation, functional and diagnostic assessment, psychiatric disability support, monitoring and problem solving, stress management, disability-related counselling, prevention of crisis or relapse, crisis intervention, psychological debriefing, personal growth/enrichment, psycho-education, skills training, case management, staff training, self-esteem building, student peer support training or facilitation, cognitive rehabilitation, behaviour or self-management training for students
- extending length and quality of vocational and educational counselling services for prospective students with mental health issues
- maximising success of students' special consideration applications by preparing templates, tracking department decisions and customising the content /wording preferences for each department

Learning skills advisor or educational counsellor

In TAFE/VET, this function is often split between counsellors, language support assistance and the academic department. At university, a specialist service is usually provided.

Opportunities for development:

- improved availability of functional assessment of learning skills, learning style, psycho-educational functioning

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- enhancement of cognitive rehabilitation/learning difficulties/ educational psychology expertise
- use of computer-assisted cognitive rehabilitation exercises
- return-to-study programs, bridging courses or short courses
- facilitation of peer support pairs, study groups/circles
- improve liaison with disability staff regarding course and testing accommodations

Teaching staff

Perceptions of the role teachers play in working with students with mental impairments can be viewed in the following ways.

Strengths:

- provision of structured learning experience which is available in TAFE/ VET
- most teachers are accommodating if mental health issues are disclosed and some strategies suggested
- most teachers very supportive
- special consideration arrangements and availability of accommodations to courses

Difficulties:

- high turnover of staff makes continuity difficult
- sessional staff have little time for meetings or one-to-one support
- potential for discrimination at selection because of lack of knowledge of implications of disability legislation
- lack of information or training on how to deal with students with mental health issues
- difficult to act appropriately if mental health issues are not disclosed

Opportunities for development:

- develop confidentiality parameters
- obtain further training on mental health issues and empathy
- obtain regular psychological debriefing when working with students with mental impairments
- separate mental health issues from behavioural issues (not always possible)
- allow for gaps in attendance due to stress/illness
- address any fears for safety with counsellor or other appropriate staff member
- enhance curriculum modification through greater flexibility in course content and assessment criteria
- request extra time allotment for addressing student's needs
- selection tests/criteria may need to be adjusted as in alternate assessment

Other support staff (e.g. notetakers and participation assistants)

A number of students access specialist support in the form of paid notetakers or participation assistants.

Current strengths:

- monitor and assist the student academically
- provide company and support as a mature companion
- assist student with organisation, planning, tracking, academic tasks
- show concern for the student's well-being and academic progress

Possible difficulties:

- notetakers' ethics prevent notetaking while student is absent unless authorised
- variable understanding of mental health issues
- lack of detailed information on student's functional deficits and how to address them
- not usually authorised to intervene with student's psychosocial and emotional issues but have to witness them, causing discomfort
- not usually trained in crisis intervention and safety
- not always trained in learning skills

Opportunities for development:

- combine and expand participation assistant role to include tutoring, notetaking and dealing with psychosocial and emotional issues in the classroom
- obtain clinical consultation, supervision and clarification from counsellor, disability liaison officer or other specialist/case worker
- co-operation in encouraging and assisting student to become more independent in learning if student agrees
- collaborate with learning skills advisor on addressing learning needs

Managers

Findings from this project suggest that best practice in relation to mental health issues on campus includes:

1. monitoring implementation of policies such as diversity, occupational health and safety, and confidentiality to mental health issues of students
2. a need for legal briefing/advice on duty-of-care for the various professionals in the department and for the manager
3. a need to continue to clarify responsibilities conferred by the Disability Discrimination Act, and consider what would constitute unjustifiable hardship in the context of mental health issues and the size of the educational institution

4 acknowledgement of resourcing implications of this client group (most DLOs the research team spoke to commented that this client group was very labour intensive)

5 acknowledgement of need for additional staff training in this field

6 a need to liaise with appropriate staff on strategies for minimising stress and preventing incidents

7 a need to address issues of unacceptable behaviour in the context of appropriate accommodations; to minimise disciplinary action if behaviour occurred during a psychotic episode; to consider on a case-by-case basis in conjunction with legal advice

8 extending curriculum modification and flexibility with course and academic rules, up to the point of unjustifiable hardship

9 a need to ensure administrative procedures do not discriminate against this client group

10 streamlining special consideration procedure, e.g. the student's psychiatric documentation to cover specified period

11 use of retrospective adjustments if student was unable to communicate needs or disclose mental health issues earlier

12 recognising that imputing a psychiatric disability or a likelihood of future psychiatric disability confers DDA responsibilities

13 arranging external mediation where there is conflict or major misunderstanding

14 building collaborative linkages with mental health services.

15 Manage critical incidents and train staff in critical incident prevention, risk assessment, intervention and postvention.

16 Practice risk management, (e.g. costs of possible litigation can be prevented by appropriate practices and resourcing of staff; learn from other litigation cases).

17 involving consumer consultants (e.g. students with mental health issues) in decision making on evaluation and improvement of services.

Principles of relating to students with mental health issues

Staff may find the following strategies useful when working with students with mental health impairments. The strategies have been drawn from discussions with DLOs, counsellors, mental health staff, consumer groups and students with mental health impairments.

Some strategies for communication

- Approach students as individuals, noting their strengths.
- Recognise that students are, or have been, mentally or emotionally suffering or unwell, through no fault of their own.
- Show empathy and repair any misunderstandings.

- Become genuinely committed to students' recovery and educational goals.
- Acknowledge students' courage to study.
- Obtain permission from the student to address their issues with other staff, otherwise don't identify by name or class to preserve confidentiality.
- Be aware of duty-of-care responsibilities if student is at risk of harming self or others.
- Familiarise yourself with basic crisis intervention steps.
- Respect the student's privacy to past experiences, otherwise you may uncover deep wounds.
- Avoid stigmatising the student or expressing doubts about their capabilities.
- Don't push students but encourage them to perform better; explore barriers and encourage them to utilise services such as learning skills advisors or counsellors.

Supported education programs as an option

Integrated support programs that incorporate high quality best practice management in key processes and implementations can provide effective support. A specific supported education (or bridging scheme) program, can focus specialist services on mental health issues and serve both students with mental health issues and staff effectively and efficiently. Specialist supported education programs are not common in Australia, but where they have been introduced they have been successful. Generalist bridging schemes are more available, and can be a useful introduction to post-secondary study for many students.

Specialist supported education programs

Psychosocial rehabilitation programs for students with mental health issues involve a strategic mix of interventions with a focus on educational and psychosocial rehabilitation. Multiple models are possible:

1. internal (on-site support)
2. external (community support system)
3. mobile support
4. self-contained classroom and clubhouse model

Best-practice implementation strategies for supported education include:

- involve key stakeholders in planning, including consumer consultants and mental health organisations
- design new service/support structure
- implement plans

- Define roles and boundaries and clarify areas of potential duplication
- co-ordinate services and policies (e.g. through matrix management models)
- build in professional development and consultation
- determine level of expertise and remuneration
- determine resources (staffing, infrastructure)
- ensure adequate funding

Program evaluation should include: outcomes evaluation, gap analysis, identification of minimum service quality indicators and benchmarkable performance indicators.

Course and system flexibility and non-discrimination

This section is adapted from a 1997 publication *Comments on discussion paper—DDA disability standards in education* (Mental Health Legal Centre Inc., Victoria). The Disability Discrimination Act (1992) confers accommodations to students with disabilities unless it would constitute 'unjustifiable hardship'.

The DDA prohibits:

- direct discrimination (DD) (treating someone less favourably because of their disability)
- indirect discrimination (ID) (requirements, conditions or practices which, though they may appear neutral, have an unfavourable impact on people with disabilities)
- discrimination on the grounds of a manifestation of a disability in some circumstances (DM)
- denial or limiting of access to benefits (LAB)
- subjecting the student to any other detriment (SD)
- harassment (HR)

Selection situations which may be discriminatory

- requirements as to previous educational or work history or performance (ID)
- requirements as to demeanour, communication skills or how a person relates to others (ID)
- prejudicial or inaccurate assumptions about the disability's impact (SD)
- mistrust or denial of credibility (SD)
- behaviour requirements (ID)

- requirements as to participation in certain sorts of activities, e.g. social activities (ID)
- a judgement that the student will not be able to meet the inherent requirements of the job later on (only employers can make this judgement)

Appropriate accommodations

- accommodations to pre-requisites for admission
- accommodations as to expectations or requirements as to how someone will interact, communicate or behave
- accommodations to student code of behaviour, student responsibilities or disciplinary requirements
- accommodations based on a person's individual needs due to their disability, not assumptions about a disability affecting all people the same way

Course-related aspects that may be discriminatory

- requirement that a course or subject be completed within a particular time frame (ID)
- requirement that a certain number of classes be attended during course (ID)
- requirement that classes be attended at a certain time of day (e.g. in the morning when a person may be particularly affected by medication) (ID)
- requirements that a student study a course or subject on campus as opposed to flexible delivery (correspondence) (ID)
- requirement that a particular load of study be undertaken (ID)
- restriction as to when the student can defer (ID)

Appropriate accommodations

- flexibility in load of study
- waiving or adjusting attendance requirements
- flexibility as to overall period of time which may be taken to complete a course or subject
- availability of flexible delivery (e.g. correspondence)
- respite periods during courses or subjects which allow students to return and complete, rather than recommence
- flexibility in timetables, priority choice for disabled students

Administrative procedures that may be discriminatory

- requirement that a person meet the usual administrative procedures associated with such matters as enrolment, withdrawal, deferment or application for special consideration (ID)

- requirement that a person will only be eligible for special consideration if they initiate the application process themselves by a certain time, e.g. three days after the assessment occurred (ID)
- non-reversal of results (ID)

Appropriate accommodations

- staff may initiate administrative procedures if previously authorised by the student
- accepting late or retrospective applications
- deletion or adjustment of results recorded if the results are a product of discrimination

Assessment-related practices which may be discriminatory

- requirement that assessment in a particular subject take a particular form, e.g. oral presentation or exam (ID)
- requirement that assessment take place at a particular time or venue (ID)
- requirement that assessment meet criteria such as spelling and structure (ID)

Appropriate accommodations

- flexibility as to form, time, or venue for assessment
- adjustment of assessment criteria such as spelling, structure, or other aspects of performance which enhance but not necessarily constitute academic understanding

Discrimination in services and benefits

- limiting access to services which facilitate study or support, such as computers, libraries, counselling services, notetaking (LAB)
- limiting access to participation in arts, sporting, social or other activities (LAB)
- lack of respite spaces (LAB)
- lack of carparking spaces when required, e.g. panic attack, social phobia (LAB)

Appropriate accommodations

- provision of counselling and support services (on an ongoing basis)
- provision of respite spaces
- access to computers, libraries
- provision of carparking spaces
- provision of notetaking

- accommodations which put the absent student in the position they would have been if they had been able to attend classes, e.g. providing notetakers not just tapes

Treatment by others that may be discriminatory

- treating the student unfavourably because of the way psychiatric disability manifests, such as the way they behave, appear physically, make eye contact, communicate or relate to others (DM)
- the student is excessively supervised or work excessively scrutinised (SD) and (DD)
- the student is relegated to menial or unsatisfying tasks (SD) and (DD)
- the student is isolated, excluded or alienated (SD) and (DD)
- the student is ridiculed, denied or vilified by other students or staff (SD) and (DD)
- the student is harassed by staff's use of demeaning, stigmatising or vilifying language related to psychiatric disability, even if not specifically directed or in relation to the student (HR)

Appropriate accommodations

- treat the student fairly and favourably even if the psychiatric disability is manifested
- adjust disciplinary and behaviour requirements
- include student in class activities or facilitate acceptance
- protect student from other students' or staff's derisory comments or language

The development of ongoing accommodation plans should anticipate and prevent impairments and detrimental manifestations of a disability. This should include accommodations for psychiatric disability that is imputed, coiuld occur in future or has invisible aspects. If someone is not performing to the required level and has not disclosed a disability, staff should consider if a disability may be having some impact and provide a safe, confidential opportunity to seek accommodations.

Suggestions for monitoring student progress

Agreement between student and staff on accommodations, implementation and evaluation should take place as part of the planning process. Monitoring is essential to evaluate whether accommodations and support are available and to what extent, whether they are effective and whether they need a review or further adjustments. It could also be that the student's needs may change over time, particularly if they can function better and have fewer or different impairments. Sometimes the

impairments and their functional implications emerge over time and take a while to be identified and articulated (e.g. which themes trigger retraumatisation).

Monitoring strategies may include:

- monthly interviews with the student
- weekly reports from tutors and participation assistants
- periodic consultation with the academic staff or course co-ordinator
- half-yearly reviews
- joint meetings between the student, tutor, academic staff, DLO and counsellor

Reviews should note what is working well and any areas for improvement. Also, a recording of relevant issues, prevention measures, and academic progress can be included. Patterns of need and strategies may be eventually identified.

Checklist of student adjustment

	Yes	No	Don't know
From a staff perspective, is the student doing an appropriate course and study mode?	❑	❑	❑
Is the student doing an academic load appropriate to their functioning? (don't underestimate)	❑	❑	❑
Is the student fully enrolled and financially coping?	❑	❑	❑
Is the student attending classes regularly?	❑	❑	❑
Is there a reasonable degree of 'fit' between the student and academic staff?	❑	❑	❑
Is there a reasonable degree of 'fit' between the student and their tutor or participation assistant?	❑	❑	❑
Are the accommodations feasible and do they achieve their goals?	❑	❑	❑
Are the travel and parking arrangements acceptable to the student?	❑	❑	❑
Is the classroom environment acceptable to the student?	❑	❑	❑
Is there a reasonable mutual tolerance between the student and other students?	❑	❑	❑
Is the student isolated in breaks, group activities, before and after class?	❑	❑	❑

	Yes	No	Don't know
Is the student experiencing any harassment, discrimination or stigma?	❑	❑	❑
Does the student appear or report being distressed and by what?	❑	❑	❑

What other support systems does the student have and use?

Is the student aware of student services and student association activities?	❑	❑	❑
Does the student communicate well without misunderstandings or problems?	❑	❑	❑

Are there any other issues to note?

Any concerns should be discussed with the student first.

Advocacy options

When differences arise between a student with mental health issues and others, an effort by a skilled person to explain the student's issues and influence treatment may be an appropriate strategy before more serious action is considered necessary (the student's permission will need to be obtained first). Some students with mental health issues may have some difficulty with expressing their point of view, their needs and being able to negotiate their rights.

If the student is able to express their needs and negotiate well, self-advocacy may be preferable as it empowers the student. The staff role may be to provide self-advocacy training or support if the student is not successful. Often, as the frontline advocate, the disability liaison officer is in a position to understand and convey the student's needs to other staff, and to refer to DDA requirements. However, as employees of the educational institution, they may find it difficult to challenge managers' decisions.

While counsellors or support workers may comprehend the student's point of view extremely well, as employees of the education system, their ability to act as advocate may be compromised. Failure to advocate and meet the student's demands successfully may reflect badly on the student-counsellor relationship. The student may feel their advocate is not effective in dealing with the system and therefore may withdraw from the counselling relationship. The counsellor may, however, support the student in other ways.

Student association officers are more removed from the institution as an employer and are therefore better placed to represent students' views. This advocate may be free to be assertive while knowing the educational system well. Some familiarity with mental health issues would be an advantage in this role.

External advocates are more knowledgeable in the student's needs and rights, and an external advocate can be a powerful influence in challenging the educational institution's decisions. Their stance will need to be taken seriously and at least compromise should be reached. Some likely sources include:

- family or friends
- mental health legal centre or similar
- disability support or advocacy services
- disability employment services
- office of the public advocate
- consumer consultant from the mental health field
- mental health organisations
- psychiatric disability support service
- treatment provider (psychiatrist, GP, psychologist)
- volunteer community advocate

Resourcing implications for mental health impairments

When the research team spoke to disability support staff about resources, many commented that while guidelines for resourcing mobility and sensory disabilities seemed clear, resourcing the support needs of students with psychiatric disabilities was less certain. The fact that this group was almost universally acknowledged as being labour intensive was not a factor in accommodation.

One staff member commented:

> *(students with psychiatric disability) are now the largest disability group and certainly the fastest growing, yet they receive the least amount of funding.*

Students also expressed concern about the support they received:

> *(disability support staff) are well meaning, but they don't seem to know what to do with me.*

The research team found the following strategies to be effective for students with mental health impairments, but all have funding implications.

- acknowledgement of the additional staff time to spend with individual students with mental health issues
- funding for consultation with specialist clinical staff; internal, sessional and external
- time allocation for case conference meetings re individual students
- time allocation for meetings to plan, develop, negotiate, evaluate extended services
- acknowledgement that full-time staffing (compared to sessional or short-term contract) has quality assurance implications for the nature of support available
- employing or developing (by providing training and study leave) specialist staff with mental health training and experience
- employing consumer consultants (e.g. ex- or current students with mental health issues)
- adequate resourcing, such as for test and assessment materials, (e.g. psychological, psycho-educational tests) and other resources such as provision of rehabilitation program resources (e.g. Captain's Log Cognitive Rehabilitation System)
- industry placement release for staff
- information on mental health issues, approaches in working with students with mental health issues, supported education, mental health services and legal issues
- developing brochures for students (print and development costs).
- group, peer support, and mentoring programs for students.
- mailing out student newsletters on mental health issues on campus (administrative and development costs)
- Joint projects with other services (e.g. staff exchange, collaborative agreements, mobile education/mental health officer)
- student skills courses/bridging programs for students with mental health issues
- development of regional resource centre on mental health issues
- acknowledgement of resource implications of case manager role

Staff and students the research team spoke to, all loudly proclaimed the need for additional training. Survey responses and focus group discussions indicated that such training should include:

- guidance in identifying behaviours which might 'trigger alarm bells'
- information about the possible side effects of medication
- knowledge of disability legislation and student rights
- mental health awareness issues

- knowledge of alternative assessment options
- training in empathy skills
- implications for field work and employment

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Section 3

Management strategies

Referral

REFERRAL IS THE process of recommending and mobilising specialist resources to assist the client deemed in need or who could benefit from more specific services. It involves the referrer recognising the boundaries of his or her role or competence and determining appropriate resources to refer to. Referrals can either be intra-institutional (e.g. utilising the counselling service) or external (accessing local mental health authorities).

General principles of referral are to:

1. express concern and explain the purpose of or need for the potential referral to the student with mental health impairment
2. provide the student with a choice of service providers, perhaps describing advantages and disadvantages of each
3. gain collaboration, if possible giving the student time to decide and information about what to expect and to facilitate decision-making
4. confer and, if necessary, negotiate with the student, the information to be communicated to the referral provider. Written consent for release of information is recommended
5. consider timelines and accessing procedure (e.g. urgency of situation, time of day, waiting lists, appointment-making or request for service)
6. communicate information to referral provider, preferably in writing or in joint meeting with the student; verbally in other cases
7. affirm the student's co-operation and choice, and preferably monitor student's actions by asking him or her whether they have seen the provider and whether it was helpful; then if *not* helpful, explore reason or other alternatives

Internal referrals can be between disability staff and counsellors; between academic or administrative staff and counsellors or disability staff; and between heads of department and managers with the counsellor, the disability staff or other staff. Referrals are more effective when the purpose or service is clearly defined.

Referrals in from external providers (intake)

Referrals of prospective students with mental health impairments may be made by various providers including: treatment providers, case managers, rehabilitation case workers, psychiatric disability support workers, or others such as family, friends or support group contacts.

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Formal referrals are beneficial because they:

- link the potential student into appropriate course information, vocational counselling, educational/disability support services and academic departments (if permitted)
- alert the informed staff of the potential or actual needs of the student, thus enabling a co-ordinated planned approach to successful educational outcomes
- provide an automatic linkage to the previous (and current) providers of services to the person, with the opportunity to divide or negotiate responsibilities

Counselling and treatment for referred students

It is important to clarify expectations from the referral agency regarding counselling. Possible options include: full or adjunct treatment relevant to coping with study and campus issues, supportive psychotherapy, stress management, educational and psychosocial counselling, skills training, rehabilitation, recovery counselling, disability support, psycho-education. It is also important to clarify whether the referring agency expects this service to be ongoing. The resource implications should also be clarified.

Collaborative linkages with external providers

Beneficial mutual agreements on objectives, authority, responsibilities and accountability can be made between the educational institution and the external agency or provider of mental health services. The purpose is to ensure that students with mental health impairments are effectively and efficiently serviced, and that services are co-ordinated and integrated.

Best practice collaboration includes:

- facilitating mutual access to case conferences, professional development and other resources (e.g. practitioner databases, medication updates)
- accessing available secondary and tertiary consultation services
- streamlining communication channels
- identifying gaps and opportunities for improvement
- working collaboratively to continuously improve services and protocols
- jointly evaluate student and collaborative outcomes
- preparing joint tender submissions for funding of projects and initiatives
- arranging joint mental health promotion activities for the student population
- extending primary and secondary prevention and early intervention in mental health to the post-secondary education environment
- undertaking conjoint strategic planning in provision of services for students with mental health issues
- identifying new services that may improve student outcomes, e.g. cognitive assessment and rehabilitation

- negotiating collaborative services and funding arrangements
- sharing success stories and celebrating together

Dealing with unusual behaviour

Unusual behaviour is not often an issue, but when it does occur it presents a challenging problem for disability support staff, who need to meet the needs of the student as well as address the concerns of management and teaching staff. Depending on the student with a mental health impairment, a range of behaviours may occur, some of which may be seen as different or even on the margins of socially or educationally acceptable standards—many staff find this confronting.

Differing perspectives

The perspective of the audience plays a significant part in defining whether a particular behaviour is different, inappropriate, unacceptable, or harmful. Cases have occurred where the behaviour of the impaired student has made great sense to the student but was interpreted negatively by others as being disruptive, rude, or dangerous.

It is generally more helpful to describe the behaviour or event in concrete terms and in full context, including the meaning, the triggers and the dynamics of the situation. The impaired student's reasons, or meaning, should be sensitively (and confidentially) elicited and carefully considered before a consequence or a 'solution' is attempted. Improved understanding of the presenting problem could be developed and options for interventions explored, perhaps by involving independent mental health consultants or mediators.

Intervention options

There are a number of intervention options open to disability and other support staff, many of which would also be useful strategies for teaching staff.

Possible strategies include:

- identifying and minimising the 'trigger' to the behaviour
- reframing the presenting 'problem' into a legitimate issue (e.g. not necessarily harassment but interest, concern, request, pressure)
- giving direct feedback to student (e.g. 'Don't stare at my legs, it's not appropriate' or 'Your voice is quite loud, would you mind softening it a little')
- suggesting 'classroom etiquette' ('Could you let the teacher know when you need to leave the class and whether you will be returning?')

- defining appropriateness ('This behaviour is OK but that one is not. Can you see the difference?')
- protecting the student when engaged in anxious, confused, or self-revealing behaviour
- calming and soothing when the student has an angry/panic state (e.g. 'I didn't mean to upset you. Is there something I can do to help?')
- following up on hints of distress or threat ('What did you mean by . . . it sounds like you're really unhappy . . .')
- defining your own boundaries (e.g. disclosure and self-disclosure, level of emotional support to student) and warmly assert your limits ('I understand this is very important to you, but I don't feel comfortable when you make reference to your sexual abuse/experiences. I imagine others might, too. It may be wiser to talk about these experiences only to very close friends or your therapist/counsellor.')
- showing friendly behaviour to students who may be anxious or fearful (e.g. by nodding when you see him or her)
- handling paranoia carefully, by placing yourself beside the student rather than face-to-face, avoiding direct eye contact, speaking clearly, not leaving any room for double meanings or misinterpretation; speaking indirectly ('they', not 'you' or 'I'), identifying with the student
- empathising with how the student might be feeling (e.g. 'I know there is a lot of pressure to get all this work done and that some of you may feel a little overwhelmed or stressed. I'm happy to see you individually to see how it could be made more manageable.')
- if the student is angry, exploring reasons and being prepared to consider contributory factors; offering and applying anger management strategies to student (Even if after investigation, there is no evidence of any obvious contributory factors, acknowledge the person's perception and express regret without agreeing with their position.)
- for students with personality disorders, obtaining specialist advice on the best ways of responding appropriately
- not dismissing a student's behaviour as attention-seeking, selfish or annoying (The student may not be able to access other ways of meeting their needs and may not be able to see his or her effects on others and they may need assistance to express their needs, fulfil them or balance them with others' needs to learn effectively.)
- for students with medium and high risk of self-harm, referring to mental health services for close monitoring and attempting to provide a safe learning environment free of triggers, potential self-harming tools and stress
- to avoid misunderstanding and conflict, using a collaborative approach whenever possible—discussing issue and options with the student and gaining their co-operation (This educates and empowers the student, making the experience more meaningful.)

Strategies for teaching staff include:

- suggesting strategies for containing 'disruption' to class (e.g. 'There is no need to explain your lateness straight away, wait until after the class.')
- addressing classroom domination with comments like 'I've heard your views and they were valuable but we need to give others a go now'
- helping the student to find solutions that allow them to feel safe (e.g. leaving the room)
- easing students with mental health impairments who are often absent or unwell, back into class (Don't feel personally rejected or dismissive of their commitment to study or ability to pass.)
- explaining unusual behaviour to other students (with student's permission) e.g. 'Maria is not well and may need to take some time out'
- making a learning agreement with the class at the start and negotiating variations as necessary

Student discipline

While the occurrence of challenging or aggressive behaviour may not be higher for students with known mental health impairments than for others, such behaviour nevertheless needs to be appropriately responded to. Most codes of conduct and disciplinary procedures allow for a conciliatory approach in the first instance.

While some professionals advocate applying the normal code of behaviour to students with mental health impairments, few consider the inclusion of accommodations. The DDA in Australia, however, prescribes the use of adjustments to services and facilities to accommodate the disabled student's impairment, unless there is unjustifiable hardship. Each individual needs to be considered on a case-by-case basis, although where there are issues of safety or threat, accommodations may not need to be provided.

Some suggested accommodations related to student discipline include:

- minimal educational penalty if the student has acted directly due to their symptoms, e.g. responded to their hallucinations or been verbally abusive during a manic episode and unable to control their behaviour
- some, but not full, consequences if the student had some but weakened control over their behaviour or giving clear feedback on what is acceptable (Don't penalise automatically if the student can't change for some time.)
- a greater number of chances to correct their behaviour, with strong expressions of concern and preventative, self-management or containment strategies (e.g. leave class until calm) instead of warnings

- referral to voluntary use of counselling, disability, or mental health services including advocacy, support, medication, treatment, advice or skills training
- renegotiation of the code of behaviour, e.g. tolerance of some swearing by the student if they have little control over it, perhaps accompanied by compensatory actions such as apology
- suspension for shorter periods of time than is customary for the misdemeanour on the principle that the same length of suspension has more deleterious effects on those with mental health impairments
- provision of taped lectures, print material and substitute practical requirements during period of suspension, to minimise educational delay or disadvantage
- appropriate use of language in disciplinary meetings or letters, to minimise punishment and authority but emphasise fairness and concern for student's or others' well-being or safety (Staff should avoid over-interpreting behaviour, e.g. storming out of a classroom is not dangerous.)
- careful investigation of triggers of behaviour, and attenuation of disciplinary penalty where provocation, misunderstanding, mistreatment, or other extenuating circumstances exist
- greater use of mediation, negotiation, advocacy, or creative complaint-resolution techniques
- maintenance of an independent appeal process
- referral to counselling service on a voluntary basis for emotional support and clarification of options
- providing the class, the students or the staff affected, with an appropriate explanation, which acknowledges their suffering and portrays the student with mental health impairments with dignity, despite their behaviour
- using conciliatory processes which enable both sides able to empathise with each other's experiences

Suggested strategies for managers dealing with student discipline

- Use independent administrators or mediators (avoid using counsellors as witnesses or administrators of code of behaviour or disciplinary procedures to ensure independence and prevent conflict with counselling function).
- Provide strategic support for staff.
- Avoid judging the student as 'unsuitable' or expelling a student prematurely (and be prepared to be flexible if a decision has to be overturned).
- Consider having clinical consultation available to disciplinary administrators where necessary.
- Seek legal advice on student management, accommodations and unjustifiable hardship parameters (and consider the legal costs if the student litigates).

- Pave the way for dignified return, by letter or phone call.
- Refer the student to other courses or services if asked to leave.

Crisis management

Crisis management is a complex task spanning across a number of structures, procedures and practices at an educational institution. It involves preparedness, prevention, crisis intervention and recovery. Talk to the management or counselling staff in the first instance about crisis management. Many institutions either have, or are in the process of establishing, processes for crisis management. If crisis management procedures are not in place, you may find it useful to consult with other institutions or with mental health organisations.

Implications for support staff

Dealing with the needs of students with mental health conditions assumes a higher standard of care will be required by all staff, not only the DLO. Teachers, administrative and reception staff and other support staff (such as counsellors and learning advisors) may be under pressure to provide higher levels of care beyond their level of competence (they may not necessarily have training and experience with students with mental health impairments). To prevent unacceptable pressure (and possible imputation of negligence), it is imperative that objectivity and levels of competence are maintained or increased by training, clinical supervision or consultation, and work experience opportunities in mental health settings. The benefits to institutions of providing appropriate services to students with mental health impairments include: increasing module completion rates, achieving diversity management goals and enabling better educational outcomes for students previously disadvantaged.

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Section 4

Implications for policy and systemic changes

Implications for policy and systemic changes

THE REPORT *Equality, diversity and excellence: Advancing the national higher education equity framework* (1996) indicates that good equity practice exists when:

1 *Equity forms part of the corporate policies, or mission of the institution;*

2 *Equity has senior advocacy in the institution;*

3 *There are sufficient numbers of dedicated staff suitably placed, or with the skills necessary to influence senior management effectively;*

4 *There is an understanding of the present and potential student population of the institution;*

5 *The institution has a student-centred approach to teaching and learning that emphasises the identification of, and response to, the needs of students;*

6 *There is an effective organisational structure in place for equity in which responsibilities are clearly identified, and which is linked in the mainstream planning and decision making processes within the institution and*

7 *There is regular monitoring and evaluation of the institution's progress towards achieving its access and equity goals.*

The implementation of support for students with disabilities (including those with mental impairments) involves systemic responsiveness which incorporates these goals.

Internal systems

Best practice intramural responses include:

- a specific program for students with mental health impairments with appropriate standards, parameters and staffing
- research into success factors, retention and non-continuation rates of particular equity groups, including those with mental impairments
- development of links with mental health organisations and services, through memoranda of understanding, inter-agency protocols, staff exchange, and mutual information and training activities
- establishment of regional cognitive assessment and rehabilitation services
- tutors and participation assistants working with students with mental health impairments to be trained in psychiatric disability support principles, specialised learning support and safety

- staff being provided with additional training in mental health issues, with Employment Assistance Program counsellors, debriefing and clinical consultation to prevent stress and burnout
- management and administrators receiving clinical and legal consultation when making decisions on services and management of students with mental health impairments
- curriculum structures, delivery and practice being sufficiently flexible and responsive to all students to cater for diversity, including those with mental health impairments who may not wish or be unable to disclose
- an independent body's being assigned to deal with appeals by students with mental health impairments in university/TAFE.
- including paid consumer consultants (preferably past students with mental health impairments) in planning, evaluation and decision-making
- providing additional remuneration for staff who have a significant load or expertise relating to mental health impairments, due to its highly complex and demanding nature and increased professional needs.

External systems

Many issues which impact negatively on the success and progression rates of students with mental impairments are extramural. The following suggestions are outside the brief of staff in educational institutions, but survey and focus group data suggest that changes to the following policies would impact positively on the success or progression rates of students with mental impairments:

Possible strategies to reduce the impact of these include:

- changes in Austudy requirements, allowing 25 per cent of a course workload for students with psychiatric disability to four hours of contact time per week
- funding being available from government mental health services to cater for psychiatric disability support and rehabilitation of students with mental health impairments in the post-secondary education setting
- similar funding being provided for treatment of students with less 'serious' mental disorders on campus
- clinical training, industry placement, and clinical supervision being provided by public mental health services to counsellors and disability liaison officers
- establishing a central resource centre on mental health impairments in post-secondary education be set up and funded by DEETYA and State departments of education.
- educational disability support funds to fund individual student case management or stress management, or support and fieldwork support in its funding guidelines.

- Austudy's changing its requirements, from only accepting evidence of mental disorder from a psychiatrist, to include psychologists in cases of less 'serious' mental disorders
- low-cost clinical psychology or social work professional development units being available for non-clinically trained staff trainers of counselling centres by professional associations and universities
- extended financial assistance, loans and grants being made available for students with mental health impairments

In conclusion

Dealing with the issue of psychiatric disability in post-secondary institutions is extremely complex. The heterogeneic nature of psychiatric disability means that its impact on learning varies considerably. This heterogeneity must, in turn, be seen against a background of individual difference in learning and thinking styles and inter and intra-institutional differences in response to disability. The issue of stigma is also a major factor; educational institutions are a microcosm of society, reflecting society's myths and misconceptions about mental illness.

Perhaps more than in other disability areas, support for students with psychiatric disability crosses a number of professional boundaries. Teachers, managers, counsellors, health professionals and mental health specialists all have strong feelings about the issue of students with mental health issues in universities and in the VET sector. The very nature of psychiatric disability also compounds the issue, in that the paranoia and impaired judgement which may be part of the illness can affect student perceptions of the support they receive.

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Appendices

Appendix A

The following tables provide suggested accommodation strategies for the following functions: perceptual, consciousness and attention, organisational and planning, cognitive, emotional, psychological, interpersonal, behavioural and physiological.

The lists are not exhaustive and individual preferences need to be taken into account.

A1 Accommodation table—perceptual functions

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Voices and other hallucinations	• distracting from tasks • confusion • misinterpretations	• can't complete tasks • distress • conceptual difficulties	• develop a barrier; e.g. 'I won't deal with that just now' • use distractions • relaxation strategies • time extensions • gently bring back to reality and reassure • monitor safety • classroom assistant
Blurred vision	• difficulty seeing, reading and writing	• delayed learning • frustration	• sit close to the front • enlarge print • tape lectures • note taker • reading and voice software
Blurred vision	• difficulty seeing, reading and writing	• delayed learning • frustration	• sit close to the front • enlarge print • tape lectures • note taker • reading and voice software
Touch or grip	• weak grip or misleading sense of touch can interfere with learning of manual skills	• inadequate manual skills	• simulated exercises • physical assistance in performing manual tasks • verbal mastery sufficient for assessment

A2 Accommodation table—consciousness and attention functions

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Focussing of attention	• difficulty in narrowing attention to specific academic tasks	• engagement with study is delayed	• colour coding • self-talk • visual symbols and cues • goals/step reminders/instructions • tape recording of lectures • remind of assessment criteria • manage distractions • tutoring • time extension
Concentration; span 1 hour limit or less is usual	• difficulty keeping on tasks	• delayed task completion	• rest breaks; e.g. 10 mins per hour • minimise distractions • time extensions • concentration training • class breaks more frequent
Disorientation in time, place or person	• unable to focus on academic tasks	• delay or non-completion of course	• arrange safety and treatment • safe retreat space • support worker/case manager • cover classes by taping , note taking
Trance, dissociations	• may 'blank out' in class or on campus; lose continuity in awareness	• reduced continuity in academic and social functioning, may be distressed or vulnerable	• support worker/case worker • safe retreat space • ask person what is happening • gradual bringing back to reality • cover classes by taping, note taking • avoid triggers • liaise with primary treatment person
Drowsiness	• hard to concentrate in class	• delayed learning	• review medication • tape class • note taker or share notes • place to 'nap' safely • study buddy to update

A3 Accommodation table—organisation and planning functions

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Self-regulatory system (the executive or meta-cognitive functions) less effective	• reduced ability to predict or monitor performance and plan, implement or adjust cognitive strategies to academic tasks	• reduced flexibility in academic and social tasks • getting stuck or delays in performance • lowered confidence	• training in meta-cognitive executive functions (cognitive rehab) • learning skills assistance, tutoring • improve self-efficacy as student • educational counselling
Reduced ability to structure activities and time	• lack of structure in study activities • time management ineffective	• goals, priorities, tasks unclear, disorganised, reduced success • missing due dates • inadequate exam preparation	• goal, priority and study plans • time management • manage distractions • balance life issues

A4 Accommodation table—cognitive functions

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Information processing delays	• slower task completion • incomplete understanding	• delay in study completion	• tutor • time extensions • extra teacher time • cognitive rehabilitation • learning skills training and assistance
Yielding to associative connections (loose connections)	• thinking and studying too wide-ranging/not focussed on specific topic	• difficulties comprehending topic or task • ideas not well organised, understood	• tutor • need clear structure and instructions • taping lectures • time extensions
Racing thoughts and stimulus overload	• difficulty in sorting significance/ priority/meaning of events	• study/learning/concentration is less effective	• break task into small steps • contain information overload
Language, speech production and comprehension impaired	• difficulty in organising word content, sentences in academic tasks • difficulty in understanding context of words	• inadequate oral or written task performance • difficulty in communicating with others on campus	• cognitive rehab • repetition of teachers' delivery, e.g. tapes of lectures • language skills training, assistance • tutoring
Reduced amount or quality of thoughts	• difficulty in processing of academic tasks	• delayed learning	• tutoring, prompting • elaboration of content • cognitive rehab • encouragement, empathy • learning skills training • time extension
Out of contact with reality, delusions	• not interpreting academic tasks and events on campus correctly • other beliefs impact negatively on academic performance	• not carrying out study goals appropriately	• prevent triggers • break/time off • reframe or redirect topic • brief student on missed work after a gap • don't agree with delusions, say you see things differently

A4 Accommodation table—cognitive functions (continued)

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Memory: especially short-term, also long-term	• difficulty in learning, remembering and recalling academic content and resources	• delay or failure in academic task performance e.g. exams	• summaries • mind maps • graphs • acronyms • flash cards • memory • alternative assessment • tutoring • study plans • time extensions
Mental blocking	• blocking interrupts thinking, academic and social tasks	• gaps in progress, delay	• prompts with new words, ideas • approach with a different point of view or starting point
Critical thinking	• difficulty in comparing, evaluating and critique of academic content	• advanced academic tasks not performed adequately	• training in critical thinking • study groups • helpful feedback • tutoring
Problem solving	• academic and social problem-solving less effective • difficulty in recognising and defining problems	• problems not addressed or resolved early	• training in problem solving • counselling • advocacy • case management/support worker
Organising ideas	• writing and academic tasks less coherent and social interaction more fragmented	• quality of academic work is sub-optimal • social relations on campus is less effective	• learning skills assistance and training • cognitive rehab • tutoring • ideas software • mindmaps
Thought disorder—overinclusion	• interpret general phenomena as personally significant	• personalise lecturer's or class comments • can destroy credibility	• explain generality of content upfront • counselling • give alternate/essay topics
Cognitive/affective processing more complex	• improvisation difficult • social tasks more difficult • academic tasks with affective content more challenging	• delayed performance in academic and social tasks and adjustment	• counselling • learning skills assistance • social skills training • time extensions • breaks to reduce stress

A4 Accommodation table—cognitive functions (continued)

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Reduced ability to generalise skills to other contexts	• difficulty in transferring skills to new academic contexts/problems/tasks	• delayed performance in learning and application of skills/knowledge	• practising transfer/generalising • more explicit instruction of similarities between contexts • tutoring • support worker/ae manager
Comprehension	• difficulty grasping meaning of academic and social tasks and context	• reduced depth of analysis • social relations less effective	• use of reading/writing structured templates • counselling/tutoring

A1 Accommodation table—emotional functions

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Vulnerable to stress	• may experience stress related to study and being on campus, such as preparing for exams, pressure of falling behind, dealing with difficult classmates	• lack of physical and/or emotional well-being may slow or compromise academic achievement or social adjustment	• stress management skills • minimise stressors • tutoring • counselling • support worker/case management • support group
Anxiety	• anxious about exams, responding to questions in class, marks, class talks, practical tests	• exam anxiety • study anxiety • performance anxiety	• coping skills • relaxation • breathing • meditation • cognitive therapy • study skills training
Depression	• low energy, motivation to study and attend	• not attending • insufficient task activity	• empathic support • break into small steps • priority setting • recognition of outcomes • feedback on quality
Fears	• fear of failure • fear of criticism	• delays or avoids academic tasks • delays or avoids receiving feedback	• counselling • provide positive feedback first then corrective • support group
Phobias	• fear of environment e.g. open space, crowding, public transport, lifts, [illegible]	• avoidance	• rearrange environment • rearrange transport • give choice of classes
Panic	• unable to function in some situations due to high level of physical and emotional distress	• missed learning opportunities, classes	• calm down, relaxation • go outside • counsellor • retreat area • time extensions • go home safely

A5 **Accommodation table—emotional functions (continued)**

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
High level of anxiety when dealing with a particular gender	• avoidance of necessary contact with people of specific gender on campus	• misinformation • lose access to resources • affects success	• provide choice of genders in staff roles • separate gender peer groups • non-threatening environment • flexible delivery • choice of mentors
Shame, humiliation	• embarrassment after unusual behaviour or for appearing 'different'	• interferes with attendance, social relations, relationships with the teacher/s	• sensitive introduction of student to class • counselling, empathic support • explanation to class re behaviour • not 'singling out' student • anti-stigma education
Distress to certain topics/words	• some topics/words/courses act as triggers	• distress prevents learning	• provide alternate topics • change stream / course
Manic state – hyperactive inflated self-esteem – irritable	• unable to complete tasks as: – overcommitted – distractable	• inconsistent performance and relating difficulties	• focussing on main priorities • breaks • refer if necessary
Low frustration level, agitation, anger	• agitation can interfere with learning	• lose task orientation • conflict • disciplinary consequences: suspension, withdrawal	• avoid or address triggers • renegotiate expectations • calming, relaxation—strategies • safe release of frustration • conflict resolution • self-advocacy training • voluntary break or go outside • anger self-management • counselling • accommodations to disciplinary measures • mediation

A6 Accommodation table—psychological functions

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Fragmenting, disorganised self (personality disintegration)	• goal instability • lack of consistency • difficulties in study planning and follow through • lack of self-control • poor resource management – time allocation – study environment – effort regulation – help seeking – peer learning	• insufficient persistence • poor study organisation and monitoring (problem solving) • uncertain course and career choices • decreased probability of module/subject completion	• vocational counselling • personal counselling/long-term therapy to build cohesion • educational counselling • goal prioritising and study monitoring • calming/structuring experience as student • self-management training • facilitate help seeking • time management skills • link in with study buddy • optimise home study environment
Vulnerable if not sufficiently validated/affirmed	• lacks ambition • demotivated if not affirmed • highly sensitive to little or negative feedback	• lack of motivation affects study effort	• constant empathic validation and affirmation of person and study effort • increased positive feedback from teachers • need recognition of doing well
Low self-efficacy (belief in own ability to do a task successfully)	• self-efficacy low for study tasks and group work	• expectations of study success drop • insufficient belief in self blocks effort to study	• build self-efficacy by providing manageable subtasks, changing self-talk
Self-monitoring impaired	• lowered detection of problems and opportunities in academic/social tasks leads to less ability to self-correct/manage study progress	• inconsistent functioning interferes with successful study and social task completion	• self-monitoring skills training • retrospective accommodations • sharing strategies with peers • keeping detailed diary and plans • sensitive feedback • advocacy • monitoring by support worker/case worker

A6 Accommodation table—psychological functions (continued)

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Lack of motivation to seek help	• help seeking is insufficient when study or wellbeing is deteriorating	• get stuck and unable to advance in academic skills knowledge • lack of resources to maintain optimal student role	• assertive case management/ support worker • personalised orientation and engagement with services and people on campus • drop-in services, casual setting • access to printed/electronic resources on services • retrospective accommodations • regular time with teachers, tutors to get assistance, sensitive feedback and opportunity to clarify tasks • offer specific/tailored instructions or options
Unclear identity	• underdeveloped student role/identity • insufficient vocational identity	• insufficient commitment and student performance	• vocational assessment and counselling • educational counselling • personal counselling • identifying strengths • observation industry placements • careers investigation
Limited insight into own impairments	• lack of understanding of how well they are coping with study • don't understand their mental health difficulties and how they impact on study	• can't articulate what supports they require or what needs they have	• help observe self • explain symptoms (psycho-education) • link behaviour to trigger • assist with identifying needs and supports • advocacy and case management • identify if close to relapse • adjust treatment
Lack initiative/motivation	• difficulty in starting and persevering with study tasks • less active relating and networking	• delayed learning • lost opportunities for social tasks	• value building • motivational counselling • vocational counselling • part time • tutoring • support group

A6 Accommodation table—psychological functions (continued)

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Resilience reduced	• studying affected by obstacles, barriers, triggers, demands, stresses	• not coping adequately with stresses in the educational environment • possible relapse	• counselling and support • learn to self-reflect and self-right • learn how to get around barriers, triggers • identify options • relapse prevention • training in problem solving and stress management • develop coping skills, e.g. self-soothing
Psychiatric disability as trauma to self-concept	• challenge to student self-efficacy • lowered study expectations • fearful of interaction due to shame or stigma	• lack confidence to start and maintain studies • highly stressed	• advocacy • empathic understanding • treatment for depression • build academic and cohesive self-concepts
Denial of mental disorder diagnosis or assessment	• without treatment, difficulties may impact on study behaviour and interpersonal relations	• not getting sufficient assistance to deal with difficulties on campus • continuation or escalation of difficulties with study	• empathy for difficulties • sensitive feedback • referral to assessment and possibly ongoing assistance • follow-up • review meetings with student and staff

A7 Accommodation table—interpersonal functions

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Communication process is impaired	• insufficient or less appropriate communication in academic and campus settings	• unclear messages • delayed messages • ineffective messages • undermine academic and social progress	• communication skills training • counselling • advocacy • support worker/case management • self-advocacy training
Dealing with change is difficult	• any change can lead to a break of trust with others or stress re study	• cannot adapt to new learning and social environment	• confidentiality important • minimise change or 'cushion' change • build trust and empathy • give plenty of notice of changes (e.g. 2 weeks minimum)
Inappropriate or unusual social behaviour	• relating difficulties on campus • behaviour may be misinterpreted or misunderstood	• reduced group participation • dysfunctional relations: e.g. conflict, harassment • avoidance	• counselling • social skills training • clarify boundaries up front • feedback on perception • mediation
Highly psychologically dependent on another person	• may be distressed in class, in study or in campus activities without safe support person/s present (e.g. unsupervised class)	• may have difficulties being independent in learning and relating to others on campus	• empathic long-term counselling • emergency teacher if teacher absent • case management/support worker • tutor/class attendant
Lack of assertiveness	• not able to negotiate preferred options in class or set boundaries for others	• lose opportunities • get left behind • vulnerable to others' manipulation	• assertiveness and self-advocacy skills training • advocacy • counselling or self-esteem • support group
Vulnerable if criticised	• stressed if getting negative feedback	• lose motivation and self-efficacy • possible conflict	• give positive and negative feedback together • strengthen self-efficacy, self-esteem

A7 Accommodation table—interpersonal functions (continued)

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Fear of social interaction	• traumatic to interact disrupted learning • uncomfortable interacting with staff and students • avoids group tasks	• lack of peer learning and networking • alienation that may protect against stress • disrupts learning and attendance • missed opportunities in networking information	• escort to classroom • stay 10 minutes initially • sit close to door • access to support worker • counselling • study buddy/peer support • referral based group activities • discussion groups (internet) • flexible delivery • exemption from attendance of groups • safe retreat space • relaxation strategies • social skills training • counselling on self-esteem • distance education
Extreme fear of others, paranoia	• avoidance, suspicion or confrontation of feared others on campus	• withdrawal, misunderstandings or challenging behaviours on campus can escalate to unsafe learning environment	• support worker/case manager • clarification of interests up front • build trust and good working relationships • unambiguous communication • retreat area • help person find safe solutions • give positive feedback when appropriate • preventative/early intervention in conflict • arrange for safety measures if threat is real
Extremely sensitive to body language and delays in responses	• feel rejected if teacher doesn't smile or is late	• withdrawal, distress	• friendly body language • minimise delays or negotiate time of answer
Need acceptance from others and have sense of belonging	• lose motivation if ostracised or ignored	• alienated from student role and others	• peer support • inclusive practices • groupwork facilitated

A7 Accommodation table—interpersonal functions (continued)

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Extremely sensitive to demands and expectations of others	• teacher or family member creates real or imagined pressure to study and student may work too hard or be unable to work	• overwork or underwork in academic tasks	• provide independent source of standards • stress management • study buddy or group
Group work difficulties	• affects compulsory group tasks	• not complete course requirement	• simulated participation • use telephone • letter as an alternative medium • working in pairs use participation assistant to facilitate communication
Strong fear of public speaking	• affects class presentation	• not complete class requirements	• alternate medium, e.g. taping • aids, such as prompts, written speech
Heightened sensitivity to others' verbal expressions	• interpret general statements or emotive phrases as personally directed e.g. 'crazy world', 'dangerous schizophrenics'	• emotionally stressful: e.g. distress, anger	• disclaimers by staff up front • ask what triggers the student • apology/regret of misunderstanding • calming down • restating the positive
Heightened sensitivity to others' feelings	• overreact to others' distress or self-harm	• over-involvement in relationships with staff or students may cause distress, disappointment, misunderstanding	• counselling • personal boundary setting • protection from others' distress if possible
Heightened sensitivity to others' opinions	• interpret staff body language and statements about student as negative, judgmental	• feel rejected, agitated, withdrawn, defensive	• eye contact, open facial expression • non-directive communication • contact/support person • positive feedback
Heightened vulnerability to stress due to conflict with others	• challenging the educational system is stressful • interpersonal relations suffer	• distress interferes • worsening of condition interferes with study	• conflict resolution • mediation • external advocate

A8 Accommodation table—behavioural functions

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Attendance lowered	• miss classes	• delayed progress	• waive attendance requirements
Disorganised behaviour	• unpredictable after triggers	• delayed progress	• calming • separate area • preserve dignity • support worker • consistent approach
Agitation (severe anxiety and restlessness)	• inappropriate classroom behaviour • inability to concentrate	• missed classes	• relaxation strategies • support worker • allow time out to pace
Obsessive-compulsive	• repeating tasks • magnifying tasks	• slower overall	• more time to complete fewer tasks
Voice loud or quiet	• loud participation • not heard	• ostracised or resented in class or on campus	• give feedback privately and with positive content • provide cues or prompts
Aggression (forceful action)	• interferes with learning • may threaten others	• alienates others	• remove triggers • state acceptable limits • access police or CAT services

A9 Accommodation table—physiological functions (some due to medication)

Functional impairment in the person	Implications for study-related tasks	Long-term effects on study	Some accommodations and interventions
Low level of energy/fatigue	• reduced effort, attendance	• delayed learning outcomes	• rest rooms • more frequent breaks • note takers and copy of o/h and notes • consider reducing load • break down steps, prioritise • double-time for course completion • self-paced or flexible delivery learning • study buddy or groups
Difficulty functioning in the morning	• miss morning classes and activities	• reduced opportunities for learning	• self-paced/flexible delivery mix • reschedule morning classes
Slowed blink response; dry eyes	• visual concentration impaired	• visual tasks more difficult to complete	• tape lectures; notetaker • substitute or decrease visual tasks • reading and voicetype software
Sleepiness (day/night reversal, insomnia)	• difficulty in staying awake during day educational activities	• reduced overall performance in day classes	• note taker • flexible delivery/alternate classes
Headaches	• interferes with study, class attendance, concentration and wellbeing	• delayed learning, missed social/ academic interactions on campus	• note taking or taping lectures • study buddy to update • safe retreat space for lying down • safe transport home
Nausea	• discomfort interferes with concentration	• absence • delayed learning	• fresh air breaks • taping lectures • attendance requirements waived • tutoring
Shakiness	• affects notetaking and practical tasks	• may delay learning or interfere with safety	• note taker/taping of lectures
Dry mouth/thirst due to medication	• need to drink frequently interferes with class rules	• discomfort reduces learning	• allow drinking in class • allow more frequent toilet trips
Sun sensitivity	• interfere with wellbeing and study	• compromises outdoor skill learning	• provide shaded areas and reduce outdoor activity

Appendix B

Bibliography

ABS (1998) *Mental health and wellbeing in Australia*, Canberra.

Arbias, (1997) *Alcohol related brain injury: Looking forward*. (kit) PO Box 213, Fitzroy, Victoria.

Australian National Association for Mental Health, *Break down the barriers of mental illness, and stigma and mental health* (brochures) Tweedie Place, Richmond 3121.

Bretag, L & Sladden, D (1996) *Supporting students with psychiatric disabilities* (a staff training package with a video) Psychology Department, University of South Australia.

DDA Disability Standards in Education—comments on discussion paper, Mental Health Legal Centre Inc., Victoria, 1997.

EPPIC, *Psychoeducation in early psychosis* (Manual 1) and other materials, 35 Poplar Road, Parkville 3052.

Exel and Associates/Tickalara Ngapa Training (1995) *Psychiatric disability and employment training package No. 1 and 2* (six modules) CRS, Disability Services Program, Department of Human Services.

Horne, A & Bennetts, L (1996) *Educational managers workshop on mental disabilities* materials, Murray Institute of TAFE, 155 Main North Road, Clare SA 5453.

Kessler, R C, Foster, C L, Saunders, W B & Stang, P E (1995) 'Social consequences of psychiatric disorders: 1 Educational attainment', *American Journal of Abnormal Psychology*, 152 (7) pp.1026–1032.

McLean, P, Bruce, G & Powell, J (1995) *Learning disabilities in higher education* (kit), DEETYA Co-operative Projects: University of Melbourne.

National Mental Health Strategy, *What is . . . ?* series (brochures) and *One in five: Living with a mental illness* (a video) Department of Human Services.

Palombo, J (1996) 'A psychological approach to attention deficit/hyperactivity disorder in adults: a paradigm to integrate the biopsychosocial model of psychiatric illness', in Goldberg, A, *Basic ideas reconsidered*, Hillsdale: The Analytic Press.

Pandos, C, Schulz, E & Bennetts, L (1991) *Scope resource file on psychological problems for tertiary education centres*, South Australia: DETAFE.

ResponsAbility (ANTA), a comprehensive staff training kit on disability issues in education).

SANE Australia, Factsheets, 'Psychosis: What is it?' and 'Blueprint' series, PO Box 226, South Melbourne 3205.

Schulz, E, *The stigma board game*, c/o North West Adelaide Mental Health Services, 78–80 St Vincent Street, Port Adelaide 5015.

Schweitzer, R, Tindle, E, Newley, K &Evans, S (1997) *Succeeding with a psychiatric disability in the university environment* (kit) Counselling Service, Queensland University of Technology.

TAFE NSW, *Management of suicidal clients of TAFE counsellors, and managing homicidal, and dangerously violent clients: Guidelines and resources* (pilot edition) Sydney Institute of Technology, Ultimo Campus: Counselling and Career Services.

TAFE National Staff Development Committee, *ResponsAbility Training Package*.

Tertiary initiatives for people with disabilities, *Creative teaching: Inclusive learning*, (a video) QUT: Beams Road, Carseldine QLD 4034.

VICSERV, *Psychiatric disability support: A resource book*, 370 St Georges Road, Fitzroy 3068.

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